NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Document level: Trustwide (TW)
Code: MP12
Issue number: 6

Antidepressant Prescribing Guidance for Adults (over 18) with **Moderate to Severe** Depression (joint document between CWP, Wirral, South, East and West Cheshire and Vale Royal CCGs)

Lead executive	Director, Compliance, Quality and Assurance
Authors details	Jasmeen Islam, Deputy Chief Pharmacist Jennifer Southern, Senior Clinical Pharmacist Dr Hisham Gaballa, Consultant Psychiatrist Abigail Cowan, Medicines Optimisation Pharmacist, Midlands and Lancashire CSU

Type of document	Guidelines
Target audience	All CWP staff Primary care prescribers
Document purpose	This pathway is a whole system approach in that it has been agreed in consultation with the CCGs. The pathway concentrates on the treatment of moderate to severe depression with medication for adults over 18 years (for child and adolescent management refer to the NICE clinical guidelines (September 2005) including comparison of anti-depressants and guidance on stopping and swapping anti-depressants. This pathway should be used in conjunction with the full depression care pathway.

Approving meeting	CWP Medicines Management Group Central & Eastern Cheshire APC Wirral Medicines Management Committee West Cheshire APC	Date 22/11/18
Implementation date	November 2018	

Document change history	
What is different?	Changes made throughout to incorporate the NICE Technology appraisal guidance (367) “Vortioxetine for treating major depressive episodes”: Published 25 November 2016. See sections; 2.5, 2.11, 2.12, 2.13 and 2.14
Appendices / electronic forms	n/a
What is the impact of change?	Low

Training requirements	No - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	• Hazel Sharp, Deputy Chief Pharmacist CWP • Dr Sumit Sehgal, Chair MMG & Consultant Psychiatrist • Dr Hisham Gaballa, Consultant Psychiatrist, CWP
Corporate services	• Medicines Management Group (CWP)
External agencies	• CCG Prescribing Group Meetings • Interface Sub Group for Medicines Management • Mark Dickinson, Head of Prescribing and Medicines Optimisation NHS Eastern Cheshire CCG, NHS South Cheshire CCG, NHS Vale Royal CCG • Abigail Cowan, Medicines Optimisation Pharmacist - Wirral Medicines Management Team, NHS Midlands and Lancashire CSU • Barbara Perry, Senior Medicines Optimisation Lead

Financial resource implications	Low

External references

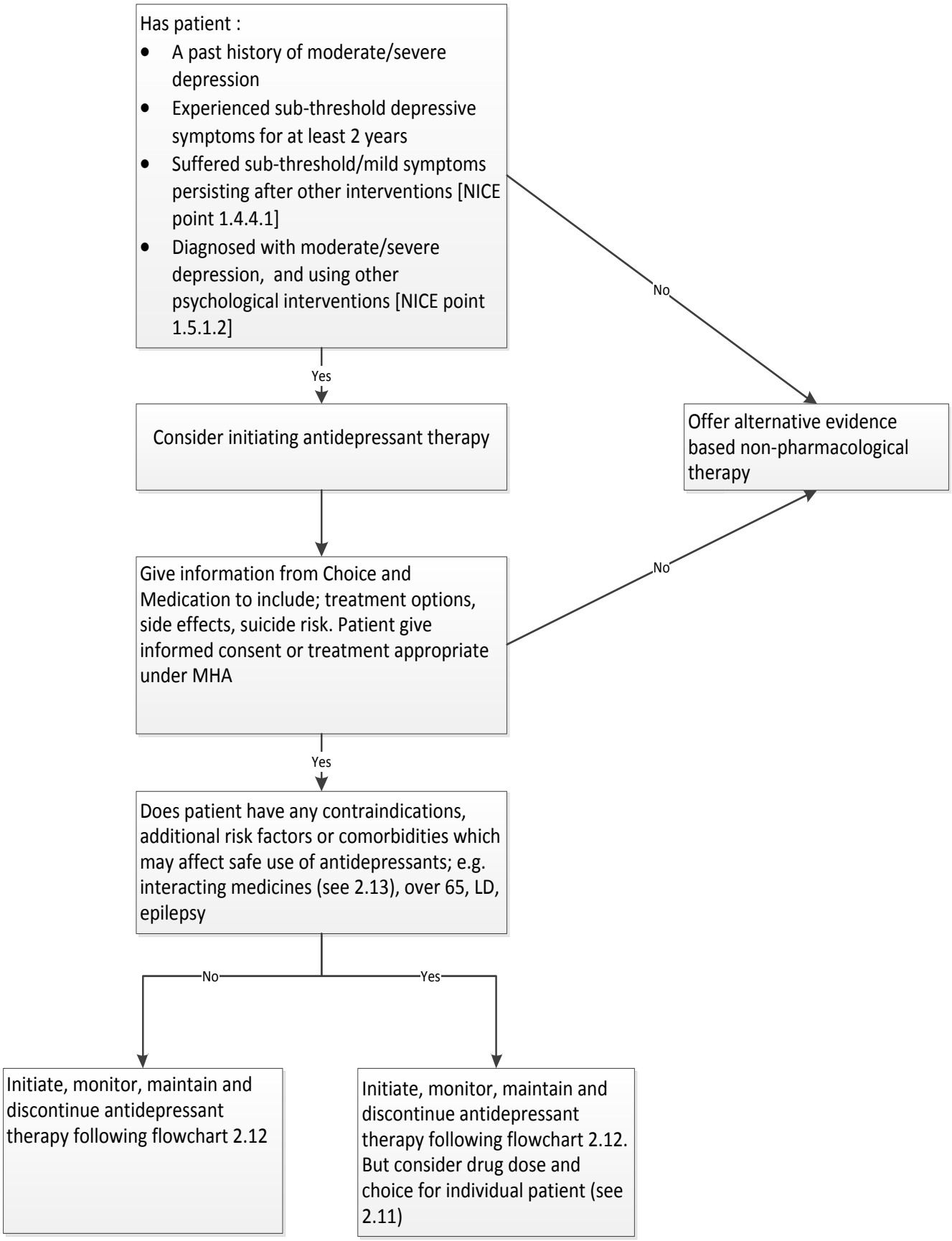
1. NICE Clinical Guidelines 90, Depression: the treatment and management of depression in adults (update)
2. NICE Clinical Guidelines 91, The treatment and management of depression in adults with chronic physical health problems (partial update of CG23)
3. NICE clinical Guidelines 28: Depression in children and young people: identification and management in primary, community and secondary care, Sept 2005
4. NICE Technology Appraisal 367, Vortioxetine for treating major depressive episodes, November 2015
5. What role for Vortioxetine? Drug and Therapeutics Bulletin, March 2016, vol 54, no.3
6. Anderson, I. M., Nutt, D. J. & Deakin, J. F. (2000) Evidence-based guidelines for treating depressive disorders with antidepressants: a revision of the 1993 British Association for Psychopharmacology guidelines. Journal of Psychopharmacology, 14, 3–20.
7. Bazire, S. Psychotropic Drug Directory 2016. Lloyd-Reinhold Publications Ltd, UK. 2016.
8. Taylor,D., Paton, C. and Kapur, S. The Maudsley Prescribing Guidelines in psychiatry, 12th and 13th Edition. Wiley Blackwell, West Sussex. 2015.
9. Kelly, C. M., Juurlink, D. N., Gomes, T., Duong-Hua, M., Pritchard, K. I., Austin, P. C., Paszat, L. F. (2010). Selective Serotonin Reuptake Inhibitors and Breast Cancer Mortality in Women receiving Tamoxifen: A Population Based Cohort Study. *British Medical Journal,* 340:c693
10. Specific Issues in Depression. MeReC Briefing, April 2002, issue no. 17: 1-5
11. The drug treatment of depression in primary care. MeReC Bulletin, 2000, vol. 11, no. 9: 33-36
12. Withdrawing patients from antidepressants. Drug and Therapeutics Bulletin, July 1999, vol. 37, no. 7
13. Selective serotonin reuptake inhibitors (SSRIs) and serotonin and noradrenaline reuptake inhibitors (SNRIs): use and safety. Medicines & Healthcare products Regulatory Agency, published 18 December 2014. Access at https://www.gov.uk/government/publications/ssris-and-snris-use-and-safety/selective-serotonin-reuptake-inhibitors-ssris-and-serotonin-and-noradrenaline-reuptake-inhibitors-snris-use-and-safety
14. https://www.mims.co.uk/table-antidepressants-guide-switching-withdrawing/mental-health/

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Comments**
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Comments
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
Select		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	No N/A N/A N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Contents

Quick reference flowchart - Antidepressant treatment pathway



1. Introduction

This Pathway is a revision of issue 5, based on the change in recommendations by NICE. As before this pathway is the result of consultation across the three CCGs we work with to agree a unified approach to how depression is managed pharmacologically across primary and specialist care. The pathway identifies the points at which referral to specialist services is recommended, as well as the pharmacological options in treatment. This Pathway should not be considered in isolation but as part of the care pathway for managing depression.

2. Initiation of depression treatment

SSRIs are usually first choice as they are as effective as other antidepressants, have lower toxicity in overdose and are generally better tolerated than tricyclic antidepressants; also see NICE CG90 section 1.5.2 and section 2.2 below, All antidepressants should be initiated in their generic form.

Initiating antidepressants should be considered in patients who:

- Have a past history of moderate/severe depression
- Have experienced sub-threshold depressive symptoms for at least 2 years
- Have sub-threshold/mild symptoms persisting after other interventions [NICE CG90 point 1.4.4.1]

Have moderate/severe depression, used in combination with other psychological interventions [NICE CG90 point 1.5.1.2]

2.1 Information for patients

Information should be provided at a level suitable for the patient. Comprehensible written information should be provided such as http://www.choiceandmedication.org/cheshire-and-wirral/

Information should include:

- The nature of depression
- Range of treatments available
- Depression is an illness which can be treated with medication
- Medicine will take at least two to three weeks to have an effect and can be up to 6 weeks
- Most side effects are self-limiting- discuss with doctor or pharmacist if concerned
- Addiction does not occur with antidepressants [NICE CG90 1.5.2.5]
- Important to take medicine every day and not stop suddenly.

2.2 Contraindications

When initiating antidepressant medication, take into account:

- SSRIs are associated with an increased bleeding risk, especially in older people. Consider prescribing a gastro protective drug in older people who are taking non-steroidal anti-inflammatory drugs (NSAIDs) or aspirin [NICE CG90 1.5.2.2]
- Toxicity in overdose for those at significant risk of suicide [NICE CG90 1.5.2.3]
- Interactions with drugs used in other conditions (see below section 2.11)
- Patient safety alerts and drug interactions detailed in the British National Formulary (BNF).
- Please note, where there are contra-indications with other medicines that prolong QT interval e.g. citalopram, escitalopram, this requires due consideration especially when psychotropic medication is augmented

2.3 Reviewing antidepressant treatment

If inadequate response to initial pharmacological treatment:

- Check adherence and side effects
- Increase monitoring
- Consider reintroducing previous treatments that have been inadequately delivered/adhered to
- Consider switching antidepressant (see section 2.6 below).

2.4 Continuation and maintenance antidepressant treatment

Continue treatment for:

- A minimum of 6 months after remission, 24 months in the elderly.
- Longer than 6 months (24 in the elderly) in patients with residual depressive symptoms and other factors increasing risk of relapse.
- At least 2 years (and consider maintenance) for people who have had two or more depressive episodes in the recent past and who have experienced significant functional impairment during the episodes

Also consider maintenance for patients who have had more than 5 depressive episodes or who have persistent risk factors for relapse/recurrence.

Continue the same dose as used during the acute phase.

2.5 Discontinuing antidepressant therapy

Discontinuation or withdrawal syndrome has been associated with the abrupt discontinuation of all doses of antidepressants and with drugs that have a shorter half-life. Symptoms usually appear within a few days of stopping the antidepressant. Most reactions are mild and rarely last more than two weeks. Withdrawal symptoms include dizziness, anxiety and agitation, abdominal spasms, low mood and mood swings. There have been isolated reports of electric shock sensations, vertigo and manic reactions on withdrawal of SSRIs (Committee for the Safety of Medicine (downloaded 2010) Report of the CSM Expert working group on the safety of selective serotonin reuptake inhibitor antidepressants).

The recommendation for discontinuing therapy is as follows:

- Taper the dose over 4 to 8 weeks if have been on treatment for 6 to 8 months.
- If have been on a maintenance dose then it is necessary to reduce the dose more slowly e.g. decrease the dose by approximately a quarter of the treatment dose every 4 to 6 weeks. Discontinuation effects are more likely with antidepressants which have shorter half- lives e.g. venlafaxine and paroxetine (NICE CG90).
- For courses of antidepressants shorter than 8 weeks, discontinue therapy over 1 to 2 weeks. This also applies when changing therapy from one antidepressant to another.
- Fluoxetine can be stopped at a dose of 20mg daily due to its long half-life and active metabolites.
- If a discontinuation reaction occurs, reassurance and explanation to the patient is required. If the withdrawal reaction is severe then consider re-commencing the antidepressant and reduce the dose more slowly (Anderson, Nutt & Deakin, 2000), (MeReC bulletin 2000, Psychotropic Drug Directory 2016)

The manufacturer of Vortioxetine suggest that it can be stopped abruptly with no need to taper the dose, however experience in clinical setting is limited and the drug still has “black triangle” status. (T1/2= 66hrs).

2.6 Switching antidepressants

When switching from one antidepressant to another, abrupt withdrawal of the original antidepressant should be avoided. Cross tapering is preferred, where the dose of the original antidepressant is slowly reduced while the dose of the new antidepressant is slowly increased. The speed is judged by monitoring patient tolerability. When switching, consider a different SSRI or better tolerated new generation antidepressant before switching to an antidepressant of a different pharmacological class that may be less well tolerated [NICE CG 90 1.8.1.2]. For some switches it may be possible to abruptly stop one antidepressant and start the next, consideration needs to be given to the pharmacology and half-life of the two antidepressants , consult references in box below for further information.

Potential dangers of simultaneously administering two antidepressants include pharmacodynamic interactions (serotonin syndrome, hypotension, drowsiness) and pharmacokinetic interactions (e.g. elevation of tricyclic plasma levels by some SSRIs).

Brief guidance on swapping from fluoxetine/citalopram/sertraline to second line choices:

- To other SSRIs – Stop citalopram or sertraline and start next SSRI. Fluoxetine has long half-life so leave washout period (4-7 days) and start SSRI at half dose.
- To mirtazapine - cross taper cautiously
- To venlafaxine or duloxetine - start at 37.5mg cross taper with citalopram or sertraline, withdraw fluoxetine and leave a 4-7 day washout period..
- To tricyclics – citalopram or sertraline reduce to minimum dose; for fluoxetine withdraw & wait 4-7 days before starting tricyclic at very low dose.
- DO NOT switch to or start dosulepin due to increased cardiac risk and toxicity in overdose [NICE CG90 1.8.1.3].

This list is not exhaustive; for further information or advice in specific cases see The Psychotropic Drug Directory 2016, Stephen Bazire and the Maudsley Prescribing Guidelines, 12th Edition, D. Taylor, C.Paton and S. Kapur or contact your local medicines information service, or if under the care of CWP the consultant psychiatrist.

Please also refer to: https://www.mims.co.uk/table-antidepressants-guide-switching-withdrawing/mental-health/ accessible by GPs, nurses or subscribers.

2.7 Serotonin syndrome

Symptoms include (also see Appendix 1 Information sheet - Serotonin Syndrome vs Discontinuation effects of Antidepressants): Restlessness, diaphoresis, tremor, shivering, myoclonus, confusion, convulsions and death.

Management of serotonin syndrome is dependent on the severity of the symptoms and for mild symptoms it is sufficient to withdraw the serotonergic medicines and monitor. For more severe symptoms it may be necessary to admit to hospital for supportive management in addition to stopping the serotonergic medicines.

2.8 Antidepressants in pregnancy and lactation

When prescribing for patients who are pregnant or planning a pregnancy do not stop antidepressants abruptly, seek information and advice first. Information about medicines in pregnancy from the UK Teratology Information Service can be found at https://www.toxbase.org/.

Please refer to NICE Guidance Antenatal and postnatal mental health: clinical management and service guidance CG192 https://www.nice.org.uk/guidance/cg192/resources/antenatal-and-postnatal-mental-health-clinical-management-and-service-guidance-pdf-35109869806789 and to Best Use of Medicines in Pregnancy (bumps) for information for patients at http://www.medicinesinpregnancy.org/.

2.9 Prescribing in older people and those with learning disabilities

When prescribing antidepressants for older people and people with learning disability:

- Prescribe at an age-appropriate dose taking into account the effect of general physical health and concomitant medication on pharmacokinetics and pharmacodynamics [NICE CG90 1.6.1.3]. Bear in mind that this group of people may have reduced renal and hepatic function due to chronic physical illness.
- Consider comorbid conditions such as epilepsy
- People with learning disabilities who are depressed can present with challenging behaviour. In such situations, antidepressant medication needs to be considered as an option. Due to complexities in presentation and communication problems, specialist advice from a Learning Disability Psychiatrist should be sought.
- Carefully monitor for side effects.

For those with learning disabilities a dose appropriate to their general physical health needs to be considered along with the pharmacokinetics and pharmacodynamics of the medicine in the individual.

2.10 Suicide risk and antidepressant treatment

A person with depression started on antidepressants who is considered to present an increased suicide risk or is younger than 30 years (because of the potential increased prevalence of suicidal

thoughts in the early stages of antidepressant treatment for this group) should normally be seen / reviewed after 1 week and then frequently thereafter as appropriate until the risk is no longer considered clinically important [NICE CG90 1.5.2.7].

Generally those over 30 years with a suicide risk would be reviewed every two weeks. The standard risk review is carried out every four weeks in those with no suicide risks.

Tricyclic antidepressants are associated with a greater toxicity in overdose and of the antidepressants recommended in primary care; venlafaxine also carries a higher risk of toxicity (NICE CG90).

2.11 Choosing an antidepressant in physical health conditions

Information here is taken from the Psychotropic Drug Directory 2016 and The Maudsley Prescribing Guidelines 12th edition. Please refer to current editions as well as the BNF (which can be found at https://www.medicinescomplete.com/mc/bnf/current/) and the Summary of Product Characteristics which can be found at www.medicines.org.uk.

Cardiovascular disease

- Sertraline or mirtazapine are generally considered safer options and there is evidence that they are safe post MI (Maudsley & PDD)
- Venlafaxine has dose dependant effect on blood pressure & heart rate (increase) check blood pressure & pulse before initiation and after dose increase (Efexor SPC accessed 23/10/2017 at www.medicines.org.uk).
- If doses venlafaxine of 300mg or above are required this should be reviewed by the psychiatrist. Combination antidepressants or adjunctive therapy may be used as an alternative to high dose venlafaxine. High doses of venlafaxine can cause high blood pressure; blood pressure should be monitored regularly.
- Patients with pre-existing cardiovascular conditions and prescribed venlafaxine, moclobemide, all tricyclics, citalopram or escitalopram are advised to have a baseline ECG and repeat as clinically indicated.
- Tricyclics should be avoided due to their cardiac side effects, lofepramine is the least cardio-toxic of the tricyclics. Cardiac arrhythmias are a contra-indication for tricyclic antidepressants and therefore an ECG should be performed to rule this out.
- Escitalopram and citalopram are contra-indicated in those with prolonged QTc or in combination with other drugs which cause QTc prolongation and an ECG must be performed before initiation to rule out QTc prolongation.
- A definitive answer is not provided in the standard references for monitoring during maintenance treatment. From clinical practice at CWP it is recommended that for patients maintained on tricyclics, citalopram, escitalopram or venlafaxine 300mg or more that blood pressure and ECG are monitored a minimum of yearly following stabilisation of dose.

Diabetes

Having diabetes doubles the odds of having co-morbid depression (Maudsley)

- SSRIs have been associated with improved diabetic parameters e.g. $HBA_{1c.}$
- Duloxetine and venlafaxine are likely to be safe but there is less supporting evidence.
- Mirtazapine can cause weight gain but effect in diabetes not established. No data for trazadone but no known problems.
- Avoid tricyclics and MAOIs
- Monitor blood glucose and HBA1c when antidepressants are started, following dose change or discontinuation (Maudsley).

Epilepsy
General advice is to keep the dose low as pro-convulsive effect is likely to be dose related and to introduce and withdraw the drug slowly.

- SSRIs do not appear to significantly increase seizure threshold. Citalopram is pro-convulsive in overdose.
- Mirtazepine appears to be relatively safe in epilepsy and Maudsley Guidelines consider it a good choice.
- No problems reported with moclobemide.
- Venlafaxine needs to be introduced and withdrawn slowly, it is pro-convulsive in overdose.
- Tricyclics do appear to lower seizure threshold, amitriptyline may be the highest risk.
- Trazadone vortioxetine and duloxetine are all cautioned in the Summary of Product Characteristics for use in epilepsy.

SSRIs and bleeding
There is an increased risk of bleeding with SSRI antidepressants. This includes GI bleeding, cerebral bleeds and perioperative bleeding.

- The risk of bleeding with SSRIs is higher in those who have had previous GI or cerebral bleeds.
- Risk is further increased when taken concomitantly with NSAIDs, aspirin or oral anticoagulants so avoid SSRIs in people who need to take these medicines.
- When it is not possible to avoid SSRIs monitor carefully and if using in combination with NSAIDs, aspirin or oral anticoagulants prescribe a proton pump inhibitor for gastro-protection (this will reduce the risk of GI bleed somewhat but will not absolutely negate the risk).

This information is taken from The Maudsley Prescribing Guidelines 12th edition and further details can be found via this reference source.

Glaucoma
Medicines with anticholinergic effects can induce or worsen narrow angle glaucoma. Tricyclics have the highest risk of anticholinergic effects amongst the antidepressants and should be avoided

Hyponatremia
May occur with all antidepressants and is particularly common in elderly patients and female gender. Co-prescription of other drugs known to cause hyponatremia e.g. NSAIDs, diuretics, ACE inhibitors, carbamazepine, calcium agonists, increase the risk.

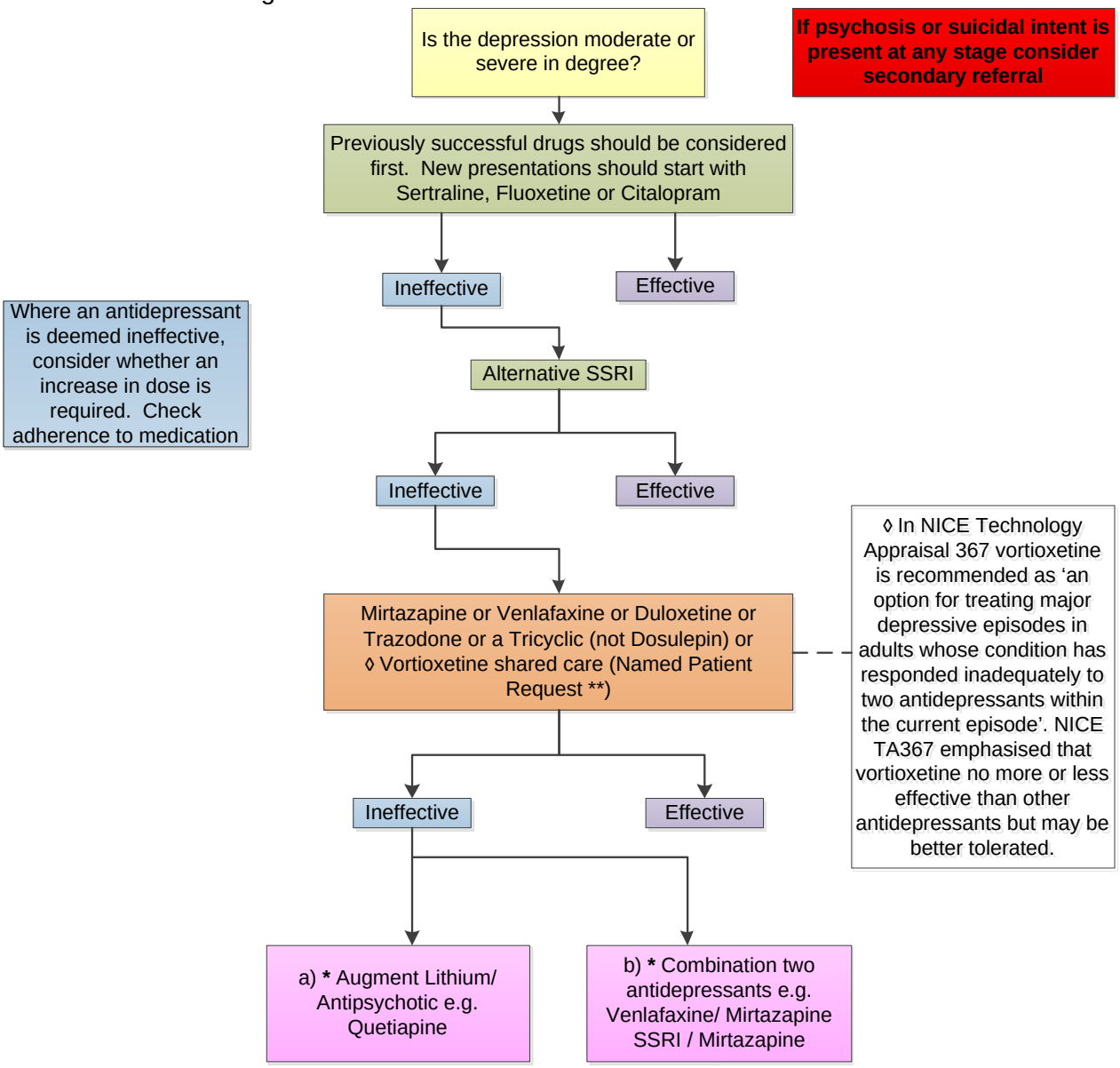
- Highest risk with SSRIs citalopram, escitalopram, fluoxetine and sertraline.
- Lowest risk appears to be with mirtazapine.

Anticholinergic burden
Anticholinergic medicines are used to treat a variety of conditions and can cause arrange of side effects including confusion, constipation, delirium, disorientation, memory impairment, agitation, risk of falls, hallucinations, dry eyes and urinary retention. There is an association (not causation) between anticholinergic use and both dementia and mortality. Prescribers need to be aware of the anticholinergic burden of drugs, particularly in those on multiple medications. Use of antidepressants should be considered alongside the patients' other medicines.

Summary:
Older tricyclics: moderate with nortriptyline, imipramine. Marked with others
Lofepramine: moderate although constipation / sweating can be severe
SSRIs: dry mouth can be a problem with paroxetine
Others: minimal with mirtazapine and venlafaxine; duloxetine – few effects

2.12 Antidepressant treatment pathway for adults (over 18) with moderate to severe depression

NB: This pathway deals with medication only, appropriate psychological therapies should be considered at each stage.



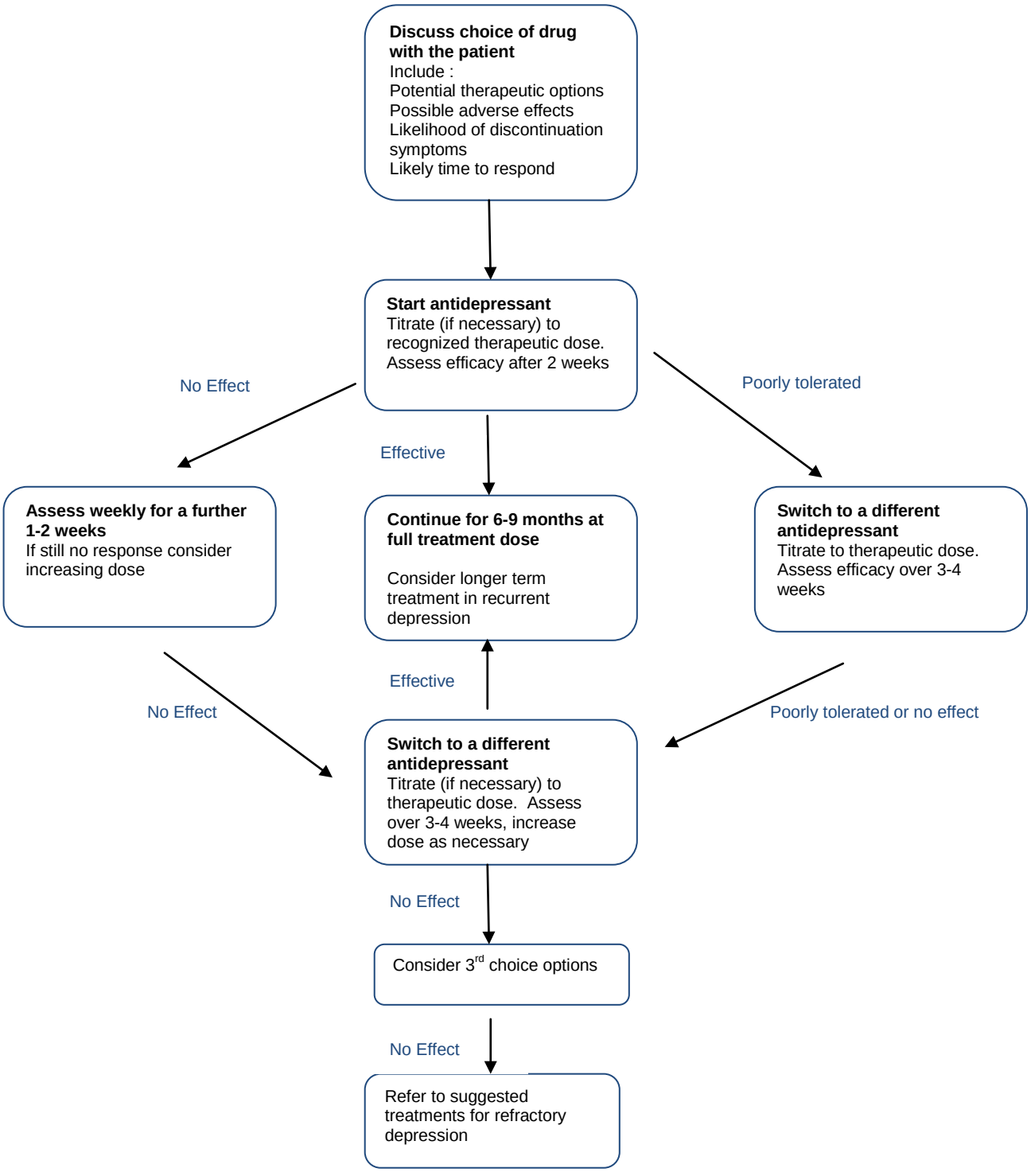
KEY:
* Specialist initiation only;
** For CWP initiation of Vortioxetine Name Patient Request must be requested from Specialist to CWP Medicines Management Group.

NOTES FOR PRESCRIBERS

Review patients as per NICE guidelines. Check adherence.
Review for response in 4 weeks. If partial response review in further two weeks.
Continue at effective dose for at least 6 months (24 months in elderly or if risk of relapse) after recovery before tapering and stopping. Continue antidepressant if at risk of relapse for at least 2 years (NICE 1.9.1.4).
Ensure patients are given information on treatment at each appointment.
DO NOT Prescribe Dosulepin, St John's Wort
MAOIs only to be initiated by specialist mental health professional
For all dosages and duration of treatment refer to NICE CG90 and the current edition of the BNF.

2.13 Drug Treatment of Depression

The following is adapted from 'Drug Treatment of Depression, The Maudsley Prescribing Guidelines in Psychiatry, 12th Edition.



Throughout decision making on treatment options check patient adherence to prescribed medication.

See BNF or the Summary of Product Characteristics at www.medicines.org.uk for dosing information

Appendix 1 - Serotonin Syndrome vs Discontinuation Effects of Antidepressants

Prepared by: Jennifer Southern, Senior Clinical Pharmacist jennifer.southern@cwp.nhs.uk, October 2017

Serotonin Syndrome
Onset usually within hours of drug or dose changes and resolves within 24 hours but it is potential fatal. Monitor for signs of serotonin syndrome if using higher doses or more than one serotonergic drug.

Signs and symptoms include:

Restlessness/agitation, Diaphoresis (excessive sweating), Diarrhoea, Nausea, Vomiting, Lack of co-ordination, Tachycardia, Fever, Tremor or Shivering, Confusion, Myoclonus, Convulsions.

Treatment : Stop all serotonergic drugs, symptomatic support e.g. keeping cool with fans, consider if benzodiazepines need prescribing.

Drugs reported to cause serotonin syndrome: Antidepressants – monotherapy or in combination.

The following drugs are reported to cause serotonin syndrome in combination with an antidepressant: Lithium, Tramadol, Fluconazole, St John's Wort, Quetiapine, Risperidone, Pethidine, Fentanyl, Linezolid, Metoclopramide, Selegiline, Olanzapine.

Discontinuation Effects of Antidepressants
When taken for six or more weeks antidepressants should be discontinued slowly unless stopping due to a serious adverse effect. Discontinuation effects usually occur within 1-2 days of stopping or reducing dose and resolve within 24 hours of restarting the previous dose.

Withdrawal/discontinuation symptoms include:
Headache
Nausea or vomiting
Flu-like symptoms
Fatigue
Abdominal cramps
Sleep disturbances, vivid dreaming or insomnia
For SSRIs may also get electric shock like sensations in head, dizziness or vertigo.

Treatment: If discontinuation effects occur then re-stabilise at previous dose and reduce by a smaller amount or over a longer period, it may be necessary to use a liquid or switch to a different antidepressant with a longer half-life or different formulations to complete the discontinuation.

References: Psychotropic Drug Directory 2016 by Stephen Bazire
The Maudsley Prescribing Guidelines 12th Edition, by David Taylor, Carol Paton and Shitij Kapur

Appendix 2 Antidepressant costs

Please see information in BNF at https://bnf.nice.org.uk/ and in the Summary of Product Characteristics for individual drugs at www.medicines.org.uk.

Costs based on 28 day prescribing for the usual dose range of each antidepressant (tricyclic antidepressants calculated at minimum dose 100mg/day).

Prices are taken from the Drug Tariff November 2017 and the November 2017 price concessions and No Cheaper Stock Obtainable (NCSO) list set by the Department of Health. The Drug Tariff and price concessions and NCSO lists are updated monthly and can be accessed at http://www.drugtariff.nhsbsa.nhs.uk/#/00488000-DB_1/DB00487996/Home and http://psnc.org.uk/dispensing-supply/supply-chain/generic-shortages/ respectively.

Drug and minimum effective dose Cost band A <£5	Drug and minimum effective dose Cost band B £5-10	Drug and minimum effective dose Cost band C £10-20	Drug and minimum effective dose Cost band D £20-30	Drug and minimum effective dose Cost band E >£30
Fluoxetine 20mg Citalopram 20mg Sertraline 50mg Escitalopram 10mg Mirtazapine 30mg Paroxetine 20mg Clomipramine 100mg Amitriptyline 100mg Venlafaxine 75mg 225mg MR**	Mianserin →	Duloxetine 60mg Moclobemide 150-300mg Lofepramine 140mg	→ Vortioxetine 10mg Trazodone (tablets or capsules*) 100-150mg Non-reversible MAOIs e.g. phenelzine →	Nortriptyline 100mg (£46.40) L-tryptophan 3g →

Where a generic product is available it should be prescribed and supplied.
*Trazodone liquid requires a non-formulary request; cost is £138.20 for 120ml 50mg/5ml.
** Venlafaxine prices vary significantly between brands
Trimipramine requires a non-formulary request; cost £380 for 100mg/day for 28days treatment